

December 21, 2010

Mr. Neville Wise, Acting Commissioner  
Cabinet for Health and Family Services  
Department for Medicaid Services  
275 E. Main Street, 6W-A  
Frankfort, KY 40621

Re: Kentucky Title XIX State Plan Amendment, Transmittal #10-006

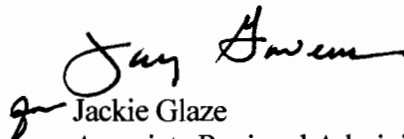
Dear Mr. Wise:

We have reviewed Kentucky State Plan Amendment (SPA) 10-006, which was submitted to the Atlanta Regional Office on September 30, 2010. This State plan amendment was submitted with pre-print page 29b, Supplement 11 to Attachment 2.6-A, pages 1, 2, 3, and Attachment 4.22-C pages 1, 2, and 3. The 90<sup>th</sup> day is December 29, 2010.

The State Plan Amendment provides for enhancement to the State's current Health Insurance Premium Program by offering "wrap around" coverage for Medicaid recipients that have other group health insurance programs available to them. It will not put the recipients Medicaid eligibility in jeopardy.

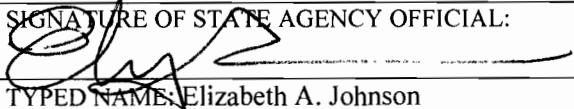
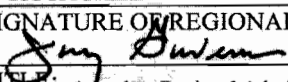

Based on the information provided, we are now ready to approve Kentucky SPA 10-006 as of December 20, 2010. The effective date is July 1, 2010. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Maria Donatto at (404) 562-3697 or Laura Killebrew at (404) 562-0151.

Sincerely,



Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		FORM APPROVED OMB NO. 0938-0193
<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 10-006
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		2. STATE Kentucky
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):		4. PROPOSED EFFECTIVE DATE 7/1/2010
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN                      X AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )		
6. FEDERAL STATUTE/REGULATION CITATION: 1902(a)(30) and 1905(a) of the Act 1902(u) of the Act 1906 of the Act.		7. FEDERAL BUDGET IMPACT: a. FFY 2010 - b. FFY 2011 -
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  29b Supplement 11 to Attachment 2.60A Attachment 4.22-C, Page 1, 2, 3		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Same
10. SUBJECT OF AMENDMENT This plan amendment provides for enhancement to our current Health Insurance Premium Program		
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services		
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Elizabeth A. Johnson		
14. TITLE: Commissioner, Department for Medicaid Services		
15. DATE SUBMITTED: September 30, 2010		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:  09/30/10		18. DATE APPROVED:  12/20/10
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:  07/01/10		20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME:  Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns
23. REMARKS:  Approved with following changes as authorized by State Agency on email dated 11/17/10:  <u>Block # 7 Changed to read:</u> 7a FFY 2010 - 1,593,400 and FFY 2011 - 7,967,000		

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Citation	Condition or Requirement
1906 of the Act	<p>State Method on Cost Effectiveness of Employer-Based Group Health Plans</p> <p>A. Cost Effectiveness</p> <p>(1) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.</p> <p>(2) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:</p> <p>a. The cost of the insurance premium, coinsurance, and deductible;</p> <p>b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;</p> <p>c. The average anticipated Medicaid utilization:</p> <p>1. By age, sex, and coverage group for persons covered under the insurance plan; and</p> <p>2. Using a statewide average for the geographic component;</p> <p>d. The specific health-related circumstances of the persons covered under the insurance plan; and</p> <p>e. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.</p> <p>B. Cost Effectiveness Review.</p> <p>(1) The department shall complete a cost effectiveness review:</p> <p>a. At least once every six (6) months for an employer-related group health insurance plan; or</p> <p>b. Annually for a non-employer-related group health insurance plan.</p> <p>(2) The department shall perform a cost effectiveness re-determination if:</p> <p>a. A predetermined premium rate, deductible, or coinsurance increases;</p> <p>b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or</p>

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- c. There is a:
  - 1. Change in Medicaid eligibility;
  - 2. Loss of employment when the insurance is through an employer; or
  - 3. A decrease in the services covered under the policy.
- (3) Changes in enrollment
  - a. A health insurance premium payment program participant, who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support within ten (10) days of the change.
  - b. Except as allowed in section (4) below, if a Medicaid enrollee who is a health insurance premium payment program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable, from the HIPP program.
- (4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection (3) of this section.
- (5) Good cause for failing to comply with subsection (3) of this section shall exist if:
  - a. There was a serious illness or death of the individual, parent, guardian, or caretaker or a member of the individual's, parent's guardian's, or caretaker's family;
  - b. There was a family emergency or household disaster – for example a fire, flood, tornado, or similar;
  - c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
  - d. There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.
- C Coverage of Non-Medicaid Family Members.
  - (1) If determined to be cost effective, the department shall enroll a family member who is not a Medicaid enrollee into the HIPP program if the family member has group health insurance plan coverage through which the department can obtain health insurance coverage for a Medicaid-enrollee in the family.
  - (2) The needs of a family member who is not a Medicaid enrollee shall not be taken into consideration when determining cost effectiveness of a group health insurance plan.

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- (3) The department shall:
- a. Pay a HIPPP program premium on behalf of a HIPPP program participating family member who is not a Medicaid enrollee; and

b. Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPPP program-participating family member who is not a Medicaid enrollee.

State: Kentucky

	(vi)	<u>Other Medicaid Recipients</u>	
1843(b) and 1905(a) of the Act and 42 CFR 431.625			The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:
	<u>X</u>		Individuals within categories listed at 42 CFR 407.42 (b)(6), including categorically needy individuals who are receiving SSI or SSP cash assistance; individuals who are treated for Medicaid eligibility purposes as though they were receiving SSI or SSP; Qualified Medicare Beneficiaries; and individuals under Attachment 2.2-A, item A. 21., who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336.
	<u>—</u>		All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV or XVI (ABD or SSI); (b) receiving State supplements under title XIV; or (c) within a group listed at 42 CFR 431.625(d)(2).
	<u>—</u>		Individuals receiving title II or Railroad Retirement benefits.
	<u>—</u>		Medically needy individuals (FFP is not available for this group).
	(2)	<u>Other Health Insurance</u>	
1902(a)(30) and 1905(a) of the Act	<u>✓</u>		The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

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	<p>COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES</p>
<p>1902(u) of the Act</p>	<p>Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:</p> <div><div></div><div>The methodology as described in SMM section 3598</div><div><input checked="" type="checkbox"/> Another cost-effective methodology as described below.</div></div> <p>A. Cost Effectiveness</p> <p>(1) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.</p> <p>(2) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:</p> <div><div>a. The cost of the insurance premium, coinsurance, and deductible;</div><div>b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;</div><div>c. The average anticipated Medicaid utilization:<div><div>1. By age, sex, and coverage group for persons covered under the insurance plan; and</div><div>2. Using a statewide average for the geographic component;</div></div></div><div>d. The specific health-related circumstances of the persons covered under the insurance plan; and</div><div>e. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.</div></div> <p>B. Cost Effectiveness Review.</p> <p>(1) The department shall complete a cost effectiveness review:</p> <div><div>a. At least once every six (6) months for an employer-related group health insurance plan; or</div><div>b. Annually for a non-employer-related group health insurance plan.</div></div> <p>(2) The department shall perform a cost effectiveness re-determination if:</p> <div><div>a. A predetermined premium rate, deductible, or coinsurance increases;</div><div>b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or</div></div>

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    - c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
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